Brief summaries of

TITLE XVIII and TITLE XIX

of the Social Security Act

MEDICARE and MEDICAID

as of
6/24/05
(with 1994 data)

NOTE: These summaries are very brief, simple versions of complex subjects. They should be used only as general overviews and guides to the Medicare and Medicaid Programs.

BACKGROUND INFORMATION

Since early in this century, health care issues have continued to escalate in importance for our Nation. Beginning in 1915, various efforts to establish government health insurance programs have been initiated every few years. From the 1930s on, there was broad agreement on the need for some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs. The main health care issue at that time was whether health insurance should be privately or publicly financed.

Private health insurance coverage expanded rapidly during World War II, when fringe benefits were increased to compensate for the government limits on direct wage increases. This trend continued after the war. Private health insurance (mostly group insurance financed through the employment relationship) was especially needed and wanted by middle-income people. Yet not everyone could obtain or afford private health insurance. Government involvement was sought.

Various national health insurance plans, financed by payroll taxes, were proposed in Congress starting in the 1940s; but none was ever brought to a vote. In 1950, Congress acted to improve access to medical care for needy persons who were receiving public assistance. This permitted, for the first time, Federal participation in the financing of State vendor payments to the providers of medical care for costs incurred by public assistance recipients. In 1960, the Kerr-Mills bill provided medical assistance for aged persons who were not so poor, yet still needed assistance with medical expenses. But a more comprehensive improvement in the provision of medical care, especially for the elderly, became a major congressional priority.

After various considerations and approaches, and following lengthy national debate, Congress passed legislation in 1965 which established the Medicare and the Medicaid programs as Title XVIII and Title XIX of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly (and in 1972, the severely disabled and certain persons with kidney disease), and Medicaid was established in response to the widely perceived inadequacy of the "welfare medical care" under public assistance.

Subsequent to their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes which continually seek, within financial considerations, to make improvements in the provision of health care services to the aged and poor. Since 1965, growth in health care expenditures have consistently outpaced growth in general revenues for all levels of government.

Health and medical care is funded through a variety of private payers and public programs. For each year from 1975 through 1990, private funds (out-of-pocket expenditures, non-patient revenues including philanthropy, industrial in plant health services, and private health insurance) paid for 58 to 60 percent of all health care expenditures. By 1993, the proportion paid by private funds had dropped to 56.1 percent. (1994 national data are not yet available).

The public share of health care expenditures has steadily increased over the past five years from 40.2 percent in 1988 to 43.9 percent in 1993. Public spending represents expenditures by Federal, State, and local governments. Of the publicly funded health care expenditures for our Nation, each of the following account for a small percentage of the total: The Department of Defense health care programs for military personnel; The Department of Veterans' Affairs health programs; payments for health care under Workers' Compensation programs; health programs under the State-only general assistance programs; non-commercial medical research; and the construction of medical facilities. Other activities which are also publicly funded include: maternal and child health services; public health clinics; school health programs; Indian health care services; migrant health care services; vocational rehabilitation services; and drug, alcohol and mental health activities.

The largest shares of public health expenditures, however, are for the Medicare and Medicaid programs, which accounted for 30.8 percent of the total health care spending in the U.S. in 1993. (By comparison, 17.8 percent of all national health care spending comes from consumers in out-of-pocket expenditures and 33.5 percent is reimbursed by private health insurance.) Medicare and Medicaid expenditures represented 70.2 percent of all publicly-funded health care spending in the U. S. in 1993, with Medicare responsible for 40 percent and Medicaid responsible for 30 percent. 1994 data for the Nation's health expenditures still unknown; but the data for Medicaid and Medicare are available. The FY 1994 Medicare and Medicaid programs' total expenditure for delivery of services and program administration was reported as $297.5 billion.

MEDICARE: A BRIEF SUMMARY

Overview

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," is commonly known as "Medicare." As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors and disability insurance benefits under other titles of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 and over. Since then, legislation has added other groups: (1) persons who are entitled to disability benefits for 24 months or more (1972); (2) persons with end-stage renal disease (ESRD) requiring dialysis or kidney transplant (1972); and (3) certain otherwise non-covered persons who elect to buy into the Medicare program (1973).

Medicare consists of two parts: hospital insurance (HI), also known as Part A; and supplementary medical insurance (SMI), also known as Part B. When Medicare began on July 1, 1966, there were 19.1 million persons enrolled in the program. By the end of 1966, 3.7 million persons had received at least some health care services covered by Medicare. In 1994, about 36.9 million persons were enrolled in one or both parts of the Medicare program. About 83 percent (84 percent of the aged) of all Medicare "enrollees" used some HI and/or SMI service in FY 1994, and thus are the 1994 Medicare "beneficiaries".

Medicare (HI and SMI) coverage

Hospital Insurance (Part A) is generally provided automatically for persons age 65 and over and to most persons who are disabled for 24 months or more who are entitled to Social Security or Railroad Retirement benefits. A major aspect of HI is the "benefit period," defined as the measurement of time-duration for inpatient care, starting when the beneficiary first enters a hospital, and ending when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by HI during a beneficiary's lifetime; but co-payment requirements (detailed later) by the Part A beneficiary do apply for days 61 through 90 of a benefit

period. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can elect to use days of Medicare coverage from a nonrenewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care.

The following describes the health services for which Part A of Medicare reimburses participating institutional providers: inpatient hospital, skilled nursing facility, home health, and hospice services that are rendered to beneficiaries enrolled in Part A.

- Inpatient hospital care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery room, intensive care, drugs, laboratory tests, X-rays, and all other medically necessary services and supplies.

- Skilled nursing facility (SNF) care is covered by Medicare HI only if it follows within 30 days (usually) a hospitalization of 3 or more days, and is certified as medically necessary. Covered services are similar to inpatient hospital, plus rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 per benefit period, with a co-payment required for days 21 through 100. Medicare HI does not cover nursing facility care at all if the patient does not require skilled nursing, or other skilled rehabilitation services which must be given on an inpatient basis.

- Home health agency (HHA) care, including a home health aide, may be furnished by a home health agency in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing, physical therapy or rehabilitation care is necessary. There must be a plan of treatment and periodical review by a physician. Home health care under HI has no time limitations, no co-payment, and no deductible. However, full-time nursing care, food, blood, and drugs are not provided as HHA services.

- Hospice care, added in 1983, is a service provided to those terminally ill persons with a life expectancy of six months or less who elect to forgo traditional medical treatment for the terminal illness, and to receive only limited (hospice) care. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services and symptom management for a terminal illness. However, if a hospice patient requires treatment for a condition not related to the terminal illness, Medicare will pay for all necessary covered services. For the hospice program, the Medicare beneficiary

pays no deductibles, but does pay a very small coinsurance amount for drugs and the cost of respite care.

Supplementary Medical Insurance (Part B) benefits are available to: almost all resident citizens age 65 and over; certain aliens age 65 or over -- even to those who are not entitled (based on eligibility for Social Security or Railroad Retirement benefits) to Part A Medicare services; and disabled beneficiaries who are entitled to Medicare's Part A. Part B coverage is optional, and must be paid for through a monthly premium. Almost all persons entitled to Part A also choose to enroll in Part B.

Part B is often thought of primarily as coverage for physician services (in both hospital and non-hospital settings). However, SMI also covers certain other non-physician services, including: clinical laboratory tests, durable medical equipment, flu vaccinations, drugs which cannot be self-administered (except certain anticancer drugs), most supplies, diagnostic tests, ambulance services, some other therapy services, certain other health care services, and blood which is not supplied under Part A.

The expenditures for institutional services in hospital outpatient departments, ambulatory surgical centers and certain other centers are also covered. All services must be medically necessary to be covered. Certain medical services and related care are subject to special payment rules including: deductibles (for blood); maximum approved amounts (for independently practicing, Medicare-approved physical or occupational therapists); or higher cost sharing requirements (such as for outpatient mental illness treatments).

Non-covered services under Medicare include long-term nursing care or custodial care, and certain other health care needs such as dentures and dental care, prescription drugs (except certain self-administered anticancer drugs), eyeglasses, hearing aids, etc. These are not a part of either the Part A or the Part B program unless they are a part of a special "coordinated care plan".

Medicare coordinated care plans

Coordinated care (prepaid health care plans), such as competitive medical plans (CMPs) and health maintenance organizations (HMOs), is an option for Medicare beneficiaries. Coordinated care plans function on a basis different from regular fee-for-service plans. Under coordinated care plans, Medicare beneficiaries receive

their medical services at a comprehensive health care setting within a service area. This public or private organization provides health care services at a predetermined per-person rate, regardless of frequency or extent of utilization by its enrollees. Coordination of all health care services is central to the HMO and CMP concept. To insure this coordination, all of the health care services, except for emergency services, are obtained by the beneficiary only from the professionals and facilities affiliated with the HMO or CMP which the beneficiary has selected.

In addition to those services which are usually provided under Medicare fee-for-service plans, the coordinated care plans often cover services such as preventive care, eyeglasses, dental care, or hearing aids. Electing to participate in a coordinated care plan may also serve as an alternative to purchasing "medigap insurance" (described later) which is often wanted if the beneficiary is in a traditional fee-for-service plan. And, although there are certain restrictions and limitations, the coordinated care plan's larger fixed monthly premiums and smaller coinsurance payments help to provide more predictability for out-of-pocket costs for the beneficiaries who do not have medigap insurance.

Program financing, Beneficiary liabilities, and Vendor payments

The Medicare program's expenses (for provided benefits and for administration) are paid for primarily from two separate trust funds. HI's funds accrue mainly from a tax on individuals' employment earnings. SMI's funds come from the payment of premiums by or on behalf of individuals, plus significant contributions from the general revenue of the Federal government. Most Medicare covered services also require some form of cost-sharing from beneficiaries.

Program financing:

For Part A, financing is, primarily, through a mandatory payroll deduction ("FICA tax") of 1.45 percent of taxable earnings (paid by each employee and the employer for each), as well as 2.90 percent for self-employed persons who pay into the HI trust fund. This hospital insurance trust fund is separate from the SMI trust fund, and from Social Security's Old Age and Survivors' Insurance and Disability Insurance trust funds. The HI trust fund money is used only for the HI program.

For Part B, financing is through premium payments ($46.10 per month in 1995) which are usually deducted from monthly Social Security benefit checks of those who are voluntarily enrolled in the SMI plan, and through significant contributions (65 percent of the total in 1994) from general revenue of the Federal government.

Beneficiary payment liabilities:

For Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program, and for various cost sharing aspects of both HI and SMI. These liabilities may be paid: (1) by the Medicare beneficiary, (2) by some other third party such as private "medigap" insurance purchased by the Medicare beneficiary, or (3) by Medicaid, if the person is eligible. The term "medigap" is used to mean private health insurance which, within limits, pays most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally-imposed standards, are offered by Blue Cross (for Part A) and Blue Shield (for Part B), and by many commercial health insurance companies.

For Part A, the beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($716 in 1995). This covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed, additional coinsurance payments ($179 per day in 1995) are required through the 90th day of a benefit period. Medicare pays nothing after day 90, unless the beneficiary elects to use "lifetime reserve" days, for which a co-payment ($358 per day in 1995) is required from the beneficiary.

For skilled nursing care under Part A, the first 20 days of SNF care are fully covered by Medicare; but for days 21 through 100, co-pay ($89.50 per day in 1995) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or co-insurance. In any Part A service, the beneficiary is responsible for fees to cover the first three pints or units of non-replaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for the HI portion of Medicare for most people aged 65 and over. Eligibility for HI is generally earned through the work experience of the beneficiary, or that of a spouse. However, some persons who are otherwise unqualified for Medicare may purchase HI coverage if they also buy the SMI coverage. The cost is

determined by a formula: If they have 30 or more quarters of coverage as defined by the Social Security Administration, the 1994 cost of HI is reduced to $183 per month; if not, the HI cost is $261 per month.

For Part B, the beneficiary's payment share includes: one annual deductible (currently $100); the monthly premiums; the co-insurance payments for Part B services (usually 20 percent of the allowable charges); a blood deductible; and payment for any services which are not covered by Medicare. These "cost-sharing" contributions are required of the beneficiaries for SMI services. For ESRD patients, Medicare Part B assists in paying for kidney dialysis and transplants. Regular Part B cost-sharing requirements also apply for ESRD services.

Vendor payments:

For Part A, prior to 1983, payment was made on a "reasonable cost" basis. Medicare payments for most inpatient hospital care are, since 1983, under a plan known as the Prospective Payment System (PPS). Under the PPS, a hospital is paid a predetermined amount, based upon the patient's diagnosis within a "diagnosis related group," (DRG) for providing whatever medical care is required during that person's inpatient hospital stay. In some cases the payment received is less than the hospital's actual costs; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly cases. Payments for home health, hospice and skilled nursing care coverage continue to be paid under the reasonable cost methodology, with each service having some restrictions and limitations. Vendor payments for Part A in FY 1994 were approximately $102.75 billion.

For Part B, physicians are paid on the basis of "reasonable charge". This was defined as the lowest of (1) the physicians's actual charge, (2) the physicians's customary charge, or (3) the prevailing charge in the locality for similar services. Beginning January 1992, the reasonable charges are defined as the lesser of: the submitted charges, or a fee schedule based on a relative value scale (RVS). Durable medical equipment and clinical laboratory services are also based on a fee schedule. Outpatient services and HHAs are reimbursed on a reasonable cost basis. Vendor payments for Part B in FY 1994 were approximately $58.0 billion.

If a doctor or supplier agrees to accept the approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full (after co-payments have been met) for

that service. No added payments may be sought from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by medigap insurance). Limits now exist on the excess which providers can charge. However, since Medicare beneficiaries may select their doctors, they have the option to choose those who do take assignment.

Medicare claims processing

Medicare contractors (intermediaries and carriers) may be public or private organizations or agencies (currently, all are private insurance agencies) that contract to serve as the fiscal agent between providers and the Federal government to locally administer Medicare's Part A and Part B.

Medicare "intermediaries" process Part A claims for institutional services, including inpatient hospital claims, skilled nursing facilities, home health agencies, and hospice services. They also process outpatient claims for SMI. Examples of intermediaries are the Blue Cross and Blue Shield Association (which utilize Blue Cross plans in various States), and commercial insurance companies.

Intermediaries' responsibilities include:

- determining costs and reimbursement amounts;
- maintaining records;
- establishing controls;
- safeguarding against fraud and abuse or excess use;
- conducting reviews and audits;
- making the payments to providers for services; and
- assisting both providers and beneficiaries as needed.

Medicare "carriers" handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plan in a State, and commercial insurance companies.

Carriers' responsibilities include:

- determining charges allowed by Medicare;
- maintaining quality of performance records;
- assisting in fraud and abuse investigations;
- assisting both suppliers and beneficiaries as needed; and
- making the payments to physicians and suppliers for services which are covered under Part B.

"Peer Review Organizations" (PROs) are groups of practicing health care professionals who are paid by the Federal government to review the care provided to Medicare beneficiaries in each State. PROs act to promote effective, efficient and economical delivery of health care services to the Medicare population they serve.

Peer Review Organizations' responsibilities include:

- deciding if care provided is reasonable and necessary;
- deciding if care is provided in an appropriate setting;
- reviewing the validity of hospitals' diagnostic information;
- reviewing the appropriateness of admissions and discharges;
- deciding if standards of quality are being met; and
- reviewing the appropriateness of care for which additional payment is sought for extraordinarily costly cases.

Administration of Medicare

The overall responsibility for administration of the Medicare program lies with the Department of Health and Human Services (DHHS) and the various components: the Health Care Financing Administration (HCFA), the Public Health Service (PHS), and the Social Security Administration (SSA). The HCFA has primary responsibility for Medicare, including: formulation of policy and guidelines; contract oversight and operation; maintenance and review of utilization records; and general financing of Medicare. The SSA is responsible for the initial determination of an individual's entitlement and has overall responsibility for maintaining the Medicare master beneficiary record. And the PHS is responsible for administering the professional health aspects of Medicare.

The Department of Treasury manages both the Medicare Part A and Part B trust funds, and the transfer of funds to pay the bills. A Board of Trustees, which is composed of two appointed members and three ex-officio members, holds the trust funds for both Part A and for Part B. The Board of Trustees reports the status and operation of the Medicare trust funds to Congress on April first of each year.

State agencies (usually State Health Departments under agreements with HCFA) assist by helping DHHS to identify, survey, and inspect provider and supplier facilities or institutions wishing to participate in the Medicare program. In consultation with HCFA, they then certify those that are qualified. The State agency also coordinates the various State programs to assure effective and economical endeavors, and assists providers as a consultant.

Medicare trends and Summary

The Medicare program covers 95 percent of our nation's aged population, plus many of the disabled persons who are on Social Security. In calendar year (CY) 1994, Medicare Part A covered 36 million enrollees at a cost of $104.5 billion (expected to be $113.9 billion in 1995), and Part B covered 35.1 million enrollees in 1994 at a cost of $60.3 billion (expected to total $69.0 billion for 1995). Administrative costs were 1.2 percent of HI and 2.8 percent of SMI disbursements for 1994. Combining the HI and SMI benefit payments for all Medicare services in CY 1994, the average disbursement per enrollee was $4,449. Of those persons who were entitled to Medicare in 1994, over 80 percent use Supplementary Medical Insurance services, while only 20 percent use the Hospital Insurance services.

The rising cost of health care is a major consideration for HCFA, for the President, and for Congress. The present schedule for financing the Part A program is sufficient to ensure the payment of benefits only for the next seven years. And although the Part B program is currently actuarially sound, the past and projected growth in the cost of the program is of grave concern. For the long range: the SMI program costs are projected to increase from 0.93 percent of the Nation's GDP in CY 1994 to 4.29 percent of GDP in CY 2069; and the HI program costs are projected to increase from 1.56 percent of GDP in CY 1994 to 4.46 percent in CY 2069.

Projections for the more immediate future indicate that, if expenditures continue at the current rate with normal growth rate for the population and if there are no significant changes to the health care programs, disbursements for the Medicare program are estimated to rise from $183 billion in 1995 to almost $222 billion for 1997.

MEDICAID: A BRIEF SUMMARY

Overview

Title XIX of the Social Security Act is a Federal-State matching entitlement program which provides medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a jointly funded

cooperative venture between the Federal and State governments to assist States in the provision of more adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people.

Within broad national guidelines which the Federal government provides, each of the States: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Thus, Medicaid programs vary considerably from State to State, and within each State over time.

Basis of eligibility and maintenance assistance status

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups designated below. And low income is only one test for Medicaid eligibility for those within these groups; their resources and assets also are tested against established thresholds (as determined by each State, within Federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. However, to be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. The following displays the mandatory Medicaid eligibility groups:

- Recipients of Aid to Families with Dependent Children (AFDC);
- Children under age 6 who meet the State's AFDC financial requirements or whose family income is at or below 133% of the Federal poverty level (FPL);
- Pregnant women whose family income is below 133% of the FPL (services to the woman are limited to pregnancy, complications of pregnancy, delivery and three months of postpartum care);
- Supplemental Security Income (SSI) recipients (or those aged, blind and disabled individuals who qualify in States that apply more restrictive eligibility requirements);

- Recipients of adoption assistance and foster care who are under Title IV-E of the Social Security Act;

- All children born after September 30, 1983 in families with incomes at or below the FPL. (They must be given full Medicaid coverage until age 19. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered);

- Special protected groups (typically individuals who lose their cash assistance from AFDC or SSI due to earnings from work or increased Social Security benefits, but who may keep Medicaid for a period of time); and

- Certain Medicare beneficiaries (described later).

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share the characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. The broadest optional groups that States will receive Federal matching funds for coverage under the Medicaid program include:

- Infants up to age one and pregnant women not covered under the mandatory rules whose family income is no more than 185% of the FPL (exact percentage of FPL is set by each State);

- Children under age 21 who meet the AFDC income and resources requirements, but who otherwise are not eligible for AFDC;

- Recipients of State supplementary income payments;

- Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL;

- Persons receiving care under home and community-based waivers;

- TB-infected persons who would be financially eligible for Medicaid at the SSI income level (but eligibility is only for TB-related ambulatory services and for TB drugs);

- Institutionalized individuals with income and resources below specified limits; and

- "Medically needy" persons (described below).

The option to have a "medically needy" (MN) program allows States to extend Medicaid eligibility to additional qualified persons with significant health care expenses who have income in excess of the mandatory or optional categorically needy levels. Such persons may "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their "excess" income, -- thereby reducing it to a level below the maximum income allowed by that State's Medicaid plan. States may also allow families to establish eligibility for MN coverage by paying monthly premiums to the State in an amount equal to the difference between the threshold allowance for income eligibility, and a family's income (reduced by any unpaid expenses incurred for medical care in previous months).

The "medically needy" Medicaid program does not have to be as extensive as the "categorically needy" program in a State, but there are certain requirements. If a State has any MN program, certain services must be provided as a minimum (the State may also choose to include additional services); and in any MN program, a State is required to provide coverage to certain children under age 18 and pregnant women who are MN. A State may elect to provide eligibility to certain other MN persons also: aged, blind, and/or disabled persons; caretaker relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. In 1994, there were 40 MN program which provided at least some services for at least some recipient groups.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 made some significant changes which affected Medicaid. Although much of the MCCA was repealed, the Medicaid portions remain in effect. For Medicaid nursing facility recipients, the MCCA protects enough of the institutionalized spouse's income and resources to assure a moderate level of support for the spouse in the community. As a result, less income and resources remain available to contribute to the cost of the nursing facility care. Thus, the institutionalized spouse qualifies for Medicaid earlier than would have been true previously.

Once eligibility for Medicaid is determined, coverage generally is retroactive to the third month prior to application. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. In addition to the Medicaid program, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal matching funds are not provided for these State-only programs.

Scope of Medicaid services

Title XIX of the Social Security Act requires that, in order to receive Federal matching funds, a State must offer certain basic services to the categorically needy populations:

- inpatient hospital services;
- outpatient hospital services;
- prenatal care;
- physician services;
- nursing facility (NF) services for persons aged 21 or older;
- family planning services and supplies;
- rural health clinic services;
- home health care for persons eligible for skilled-nursing services;
- laboratory and x-ray services;
- pediatric and family nurse practitioner services;
- nurse-midwife services;
- certain Federally-qualified ambulatory and health-center services; and
- early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive Federal assistance for funding if they elect to provide other approved optional services. A few of the optional services under the Medicaid program include:

- clinic services;
- nursing facility services for the aged and disabled;
- intermediate care facilities for the mentally retarded (ICFs/MR);
- optometrist services and eyeglasses;
- prescribed drugs;
- prosthetic devices;
- dental services; and
- TB-related ambulatory services & drugs for qualifying persons.

States may provide home and community-based care to certain persons with chronic impairments. Another option allowed eight States (as a demonstration project) to establish and provide community-supported living arrangement services for persons with mental retardation or a related condition.

Amount and duration of Medicaid services

Within broad Federal guidelines, States determine the amount and duration of services offered under their Medicaid programs. They may limit, for example, the number of days of hospital care or the number of physician visits covered. However, States are prohibited from limiting the duration of coverage for medically necessary inpatient hospital services provided to Medicaid-eligible children under age six who are in "disproportionate share hospitals" (defined below) and to infants in all hospitals.

With certain exceptions, a State's Medicaid Plan must allow recipients to have freedom of choice among participating providers of health care. States may provide and pay for Medicaid services through various pre-payment arrangements, such as health maintenance organizations (HMOs).

In general, States are required to provide comparable amounts, duration and scope of services to all categorically-needy eligible persons. But there are two important exceptions:

1) Health care services identified under the EPSDT program as being "medically necessary" for eligible children must be provided by Medicaid, even if those services are not included as part of the covered services in that State's Plan (i.e., only these specific children might receive those specific service); and

2) States may request "waivers" for home and community-based services (HCBS) under which they offer an alternative health care package for persons who might otherwise be institutionalized under Medicaid (i.e., only those persons so designated might receive HCBS). States are not limited in the scope of services they can provide under such waivers as long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients).

Payment for Medicaid services

Medicaid operates as a vendor payment program, with States paying providers directly. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. With a few specific exceptions, each State has broad discretion in determining (within Federally-imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services.

States may impose nominal deductibles, coinsurance or copayments on some Medicaid recipients for certain services. However, certain Medicaid recipients must be excluded from cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy enrollees in HMOs. In addition, emergency services and family planning services must be exempt from co-payments for all recipients.

The portion of each State's Medicaid program which is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. By law, the FMAP cannot be lower than 50 percent nor higher than 83 percent. The wealthier States have a smaller share of their costs reimbursed. In 1994, the FMAPs varied from 50 percent (paid to 11 States and D.C.) to 78.9 percent (to Mississippi), with the average Federal share among all States being 57.5 percent.

The Federal government also shares in the State's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50 percent for all States. However, depending on the complexities and the need for incentives for a particular service, higher matching rates are authorized for certain functions and activities.

Federal Medicaid payments to States have no set limit (cap); rather, the Federal government matches (at FMAP rates) the State payments for the mandatory services plus the optional services that the individual State decides to provide for eligible recipients. Reimbursement rates must be sufficient to enlist enough providers so that Medicaid care and services are available under the State Plan at least to the extent that comparable care and services are available to the general population within that geographic area.

States also must augment payment to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income persons under what is known as the "disproportionate share hospital" (DSH) program. Under this program -- which was coupled with refundable donations and provider taxes -- some States made large DSH payments in order to get higher Federal matching monies with little or no increase in the State's share. However, under legislation passed in 1991, these DSH payments are now limited.

Medicaid trends and Summary

Medicaid was initially formulated as a medical care extension of Federally funded income maintenance programs for the poor, with an emphasis on dependent children and their mothers. Over the years, however, Medicaid has been diverging from a firm tie to eligibility for cash programs. Recent legislation assures Medicaid coverage to

an expanded number of low-income pregnant women, poor children and to some Medicare beneficiaries who are not eligible for any cash assistance program. Such persons would not have been eligible for Medicaid under earlier legislation. Legislative changes also focused on increased access, better quality of care, continuation of specific benefits, enhanced outreach programs, and fewer limits on services.

Medicaid policies for eligibility and services are complex, and vary considerably even among similar-sized and/or adjacent States. A person who is eligible for Medicaid in one State might not be eligible in another State. Services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. And Medicaid eligibility and/or services within a State can change during the year.

The Managed Care concept, which is growing rapidly within the Medicaid program, seeks to enhance access to quality care in a cost effective manner. As of June 30, 1994, 7.8 million Medicaid recipients had enrolled in Medicaid Managed Care programs, and the number of participants is increasing rapidly.

The biggest change from the original Medicaid program has been the growth of Medicaid's substantial role in long-term care. An average of almost 45 percent of care for persons using nursing facility or home health services in the U.S. in recent years was paid for by the Medicaid program. A much larger percentage is paid by Medicaid for those persons who used more than four months of such long-term health care. Medicaid payments for institutional and community-based long term care in 1994 totaled almost $46 billion.

Since its inception, increases in expenditures for the Medicaid program have exceeded the consumer price index, and have exceeded the increase in total numbers of persons served and the increase in services provided. This continually increasing growth in Medicaid expenditures seems primarily due to four factors:

- the increase in rates of payments to providers of medical and health care services, when compared to general inflation;

- the results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive, but in need of continued extensive and very expensive care;

- the increase in the numbers of very old and disabled persons requiring extensive acute and/or long term health care and various related services; and

- the increase in the size of the Medicaid-covered populations (a result of the economic recession and Federal mandates).

Most Medicaid recipients require relatively small expenditures per person, per year. For example, the data for 1994 indicate that Medicaid vendor payments for over 17 million children under age 21 averaged only $1,006 per child. Other groups, comprised of far fewer persons, have much larger per-person expenditures; e.g., the 158,800 recipients of ICFs/MR care in 1994 who averaged $55,300 per person in Medicaid payments to ICFs/MR (plus the cost of acute care and other services they received outside of the ICF/MR facility). And at least 40 percent of persons with AIDS have their health care (estimated in 1992 to be about $40,000 per person per year) paid for by Medicaid.

Although the recipient numbers are relatively very small, some individual patients (e.g., severely burned patients, accident or violence victims with multiple severe head and brain injuries, medically fragile very premature babies, organ transplant patients, and others requiring very specialized, extensive and intensive medical care) can cost over $4,000 per day/per person. And a few persons require continuing extensive and very complex health care for many years, costing several hundreds of thousands of dollars per person, year after year.

Data indicate that over 40 million persons were enrolled in Medicaid in 1994. Of these, 35.5 million received at least some health care service in 1994 through the Medicaid program. Total 1994 outlays for the Medicaid program include: vendor payments of $109 billion, payments for various premiums (for HMOs, Medicare, etc.) of almost $11 billion, payments to disproportionate share hospitals of nearly $17 billion, plus administrative costs. Total increase was from $126 billion for 1993 to $137 billion for 1994 ($79 billion in

Federal and $58 billion in State monies). This meant an average 1994 Medicaid payment to vendors of $3,070 per Medicaid recipient.

Medicaid's compound rate of growth for the existing program is now projected to be nine percent per year between the years 1994 and the year 2000. Thus, if current expenditure trends continue, and there are no significant changes to the Medicaid program, then payments for the total (Federal and State) Medicaid programs may exceed $230 billion by the year 2000.

The U.S. Congress, the Department of Health and Human Services and the individual States continually seek to make improvements in the Medicaid programs' quality, effectiveness and extent of health care services. The need for expanded eligibility and more extensive and enduring services is obvious. However, the Medicaid programs must function within the various Federal and State constraints of economic, social, and political factors. As a balance for these factors is sought, revisions continue to occur in Federal laws, in HCFA regulations, and in the States' Medicaid Plans. Thus, the Medicaid programs are continually changing.

THE MEDICAID - MEDICARE RELATIONSHIP

Most aged and/or disabled persons who are very poor are covered under both the Medicaid and Medicare programs. These persons may receive the Medicare services for which they are entitled as well as other services available under that State's Medicaid program. As each State elects for its Medicaid Plan, services (such as hearing aids, eyeglasses and nursing facility care beyond the 100 days covered by Medicare) may be provided to these persons by the Medicaid program. And the Medicaid program pays all of the cost-sharing portions of Medicare Part A and B for these fully-eligible persons.

In addition, there are other Medicare beneficiaries (QDWIs, QMBs or SLMBs - see below) who are not fully eligible for Medicaid, but who do receive some help through a State Medicaid program's payment of part or all of the person's Medicare premiums and cost-sharing expenses. Persons identified as Qualified Disabled and Working Individuals ("QDWIs") who lost Medicare benefits because of their return to work are allowed to purchase Medicare HI and SMI coverage. However, the HI premium (but not the SMI premium) must be paid by the State Medicaid program for QDWIs with incomes below 200 percent of the Federal Poverty Level.

Other Medicare beneficiaries who may receive some assistance are those known as Qualified Medicare Beneficiaries ("QMBs") and those known as Specified Low-Income Medicare Beneficiaries ("SLMBs"). For the QMBs, (those Medicare beneficiaries who have incomes below the FPL and resources at or below twice the standard allowed under the SSI program), the State pays all the Medicare cost-sharing expenses and premiums for Medicare HI and SMI. For the SLMBs, (beneficiaries with resources like QMBs, but with slightly higher incomes: less than 110 percent of FPL in 1993 and 1994, and less than 120 percent in 1995), the Medicaid program pays (only) the SMI premiums.

Medicaid is always to be the "payor of last resort"; thus if a person is a Medicare beneficiary, then payments for any services covered by Medicare are made by the Medicare program before any payments are made by the Medicaid program.

CONCLUSION

Our Nation's expenditures for health care services in 1994 approached $1 trillion, and may have been as much as 14 percent of the Nation's gross domestic product (GDP). These health expenditures are a major concern of the Administration and Congress. The dynamic interrelationship of various factors, needs and financial limitations will have a major influence on future national health care programs and their costs. The ability of the Nation to provide good health care, yet contain health care costs, faces uncertainty.

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